

Homelessness and Mental Health:

Voices of Experience



Mental Health Reform
Promoting Improved Mental Health Services



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Homelessness and Mental Health: Voices of Experience

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Introduction

This study grew out of a Dublin Simon Community Client Action Group (CAG) event on mental health which took place in November, 2014. The CAG's *Speak Out on Mental Health* event showed that there was a strong interest among homeless people in having improved mental health services.

Charities and voluntary sector organisations working with homeless people have also raised concerns to Mental Health Reform about their clients' access to mental health services. Concerns raised by Mental Health Reform's Homeless Sector Advisory Group included:

- Gaps in the availability of crisis support. The recommended route for accessing crisis mental health services out of hours is to attend an Emergency Department (ED); however, homeless sector groups have advised that this is not an appropriate or realistic option for homeless people who are unlikely to wait the many hours necessary to get seen through an ED
- The need for an in-reach mental health service within homeless services so that when a homeless service staff member is concerned about the mental health of a client, they can ask the in-reach service to visit directly
- A lack of follow-up for homeless people after discharge from inpatient services. Concern has been expressed about a lack of discharge planning for individuals discharged from inpatient settings, including the Central Mental Hospital
- Difficulties accessing specialist mental health services if the person has a problem with substance/alcohol misuse

As part of its mission to support collective advocacy, Mental Health Reform sought funding in partnership with Dublin Simon Community

for the *Homeless Adults Speak Out on Mental Health* project. The project combines research and campaigning to address the evidence gap and engage in direct action to address identified service needs.

Not surprisingly, severe mental health difficulties are more prevalent among homeless people than the general population. Dublin Simon's Health Snapshot for 2013 showed that 71% of its clients had a diagnosed mental health difficulty, of which 22% had a diagnosis of psychosis or schizophrenia. The Dublin Simon prevalence of psychosis or schizophrenia is consistent with international evidence on the incidence of severe mental health difficulties among homeless people, which is approximately 25%¹. This is much higher than the prevalence expected in the general population, where approximately 1% of adults have schizophrenia. These figures are also supported by O'Reilly, et al's study on health and homelessness in Dublin and Limerick which found that 51.5% of participants had a mental or emotional health difficulty that prevented them from carrying out normal daily activities, and 58% had at least one mental health diagnosis.² One likely reason for the high prevalence of psychosis and schizophrenia diagnoses among homeless people is the interplay between severe mental health difficulties and housing need. Research conducted in the Tallaght inpatient mental health service found a high proportion of individuals with a housing need, with an average of 38% of inpatients and 98% of long stay/

1 See College of Psychiatry Ireland (2011) 'Specialist Mental Health Services for Homeless People: Position Paper EAP02/2011', available at www.irishpsychiatry.ie and National Coalition for the Homeless (USA) (2009) 'Mental Illness and Homelessness' available at www.nationalhomeless.org.

2 O'Reilly, F., Shriver, S., Hannigan, A., Barror, S. Ruane, L., MacFarlane, A. and O'Carroll, A. 'Health and Homelessness in Ireland: From Economic Boom to Bust', powerpoint presentation received via direct correspondence with F. O'Reilly.

delayed discharge inpatients having a lack of adequate housing. The study also found that there was a discharge to homeless services every 9.4 days.³

Another possible factor linking mental health service users with homelessness is their past experience of involuntary treatment. A study among 50 Cork Simon Community clients⁴ found that of the 68% of participants who had a mental health difficulty, 44% had been admitted previously to inpatient care. Within the group of those with experience of inpatient care, half had been admitted involuntarily, a much higher percentage than the national rate of approximately 10%.

Barror, et al (2014) looked at eight homeless people's experiences of health services in Dublin.⁵ The study found that clients had a lack of access to mental health services but that in some cases this might have been due to lack of knowledge about where to go rather than a lack of availability of services. Significantly for this study, the authors identified participants who were regularly attending a methadone clinic but not receiving treatment for their mental health difficulty. It is noteworthy that the sample for this study involved referral from a GP and therefore meant that the individuals were already engaged to some extent with a health service. This may not be the case for all of the Dublin Simon

Community clients.

Based on the above-cited research conducted to date in Ireland, there appeared to be no research exploring the history of homeless people's interactions with mental health services, or research that documented homeless people's own perspectives of the barriers they have faced in accessing mental health supports. Mental Health Reform considered this an important gap in the evidence base. In particular, MHR assessed that it would be useful to undertake narrative research to learn about individuals' stories of interactions with mental health services before and during their period of homelessness to identify possible opportunities to prevent people with severe mental distress from becoming homeless. Therefore MHR commissioned Dr Rebecca Murphy to carry out a narrative research study with a view to provide an evidence base for the '*Homeless Adults Speak Out on Mental Health*' campaign.

The following report sets out the findings of the research phase of the '*Homeless Adults Speak Out on Mental Health*' campaign. However, before presenting the research process, the next chapter explains the policy context for mental health services for people experiencing homelessness in Ireland.

3 Cowman, John (unpublished) 'Prevalence of housing needs among inpatients: An audit of housing needs, over one year, in the acute mental health unit in Tallaght Hospital'.

4 O'Reilly, O. (2013) How Did I Get Here?: Cork, Cork Simon Community.

5 Barror, S., O'Carroll, A. and O'Reilly, A. (2014) Lived Experiences of Homelessness and Mental Health, powerpoint presentation summarising findings, received by personal correspondence.

Policy framework

The provision of services that contribute to good mental health among people who are homeless, and that prevent homelessness among people with mental health difficulties, are shaped by relevant Irish and international policy and law.

Mental health services affecting homeless people in Ireland have been influenced by successive Government policies advocating de-institutionalisation and a move to community-based mental health care. Significant in this process has been the closure of separate psychiatric hospitals and a reduction in the number of inpatient beds. Where previously the existence of separate psychiatric hospitals may have enabled easier, direct access to acute care for homeless people and people with substance misuse issues, the recent reduction in inpatient beds combined with a changed access route towards EDs have created new barriers to accessing acute care for people who are homeless.

Parallel to this reduction in access to inpatient beds, the development since the 1980s of strict catchment-area boundaries has raised a geographical barrier to mental health services for individuals who may have originated in one catchment area but now, due to homelessness, reside in a different area or have no fixed abode and are therefore rejected from one or another catchment area's mental health service.

The more recent policy of transferring HSE-supported accommodation from the health service to local authorities, set out initially in the national mental health policy *A Vision for Change*⁶ and further developed in the *Housing*

Strategy for People with Disabilities,⁷ runs the risk of further distancing people with severe mental health difficulties from secure accommodation, since they will be in competition for housing with other marginalised groups on local authority housing lists.

Therefore in some ways, national mental health policy has militated against services that prevent homelessness and provide adequate care to people who are homeless.

Nevertheless, some Irish policy recommendations and obligations under international human rights law provide a basis for advocating for better services than are currently in place. This chapter sets out some of the national policy and international human rights framework that can underpin improvements in mental health services for people who are homeless and housing provision for people with severe mental health difficulties.

Mental health services for homeless people

The right to the highest attainable standard of physical and mental health, which applies to all people, is set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), ratified by Ireland in 1989.

According to Amnesty International Ireland:

“Under the right to the highest attainable standard of mental health, mental health services should be available, accessible, acceptable and appropriate in quality. Availability refers to the fact that there must

⁶ Department of Health (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*, Dublin, Stationery Office.

⁷ Department of the Environment, Community & Local Government (2011) *National Housing Strategy for People with Disabilities 2011-2016*, available at www.housing.gov.ie.

be enough mental health-related facilities and services as well as sufficient trained medical and other professionals. Accessibility refers to how appropriate facilities, goods and services must be affordable, geographically accessible and available without discrimination. It also requires that information about services must be available and accessible. Acceptability refers to how facilities, goods and services must respect different cultures and medical ethics. Quality refers to how facilities, goods and services must meet medical and scientific standards of quality.”⁸

Of particular concern in the context of homeless people is that States are required to take steps to ensure that this right is enjoyed by vulnerable groups. For example, the UN Committee on Economic, Social and Cultural Rights has stated that:

“... health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.”⁹

For individuals experiencing homelessness, the provision of mental health services that meet their specific needs is of paramount importance. This includes increasing access to appropriate mental health services and supports and ensuring appropriate discharge planning and follow on care, such as access to housing. There is no doubt that secure and long-term housing is fundamental to promoting the recovery of people

with mental health difficulties, including people who are homeless.

Ireland's current mental health policy, *A Vision for Change* includes a dedicated chapter on special categories of mental health service provision. The Expert Group recommended the development of mental health services for people who need supports not typically provided by generic mental health services, including homeless people. Specifically, the Expert Group recommended the following:

- The Community Mental Health Team (CMHT) with responsibility and accountability for the homeless population in each catchment area should be clearly identified
- Two dedicated multidisciplinary CMHTs for homeless people should be established - one for North Dublin and one for South Dublin
- Homeless CMHTs should be based in, and operate from, community mental health centres
- Homeless CMHTs should provide assessment, treatment and care on an assertive outreach basis
- Two day centres and one day hospital should also be provided for these teams
- One crisis house of ten beds for those not requiring admission to acute psychiatric beds should be established
- The use of acute psychiatric beds if required, from the overall complement for the Dublin area
- The establishment of a database in order to explore the issue of homelessness, analyse how services are currently dealing with it, and make recommendations as to requirements for effective service provision and implementation of same

⁸ Amnesty International Ireland (28 August 2009) 'Accountability in Mental Health Services: The Significance of the Indecon Review' available at <https://www.amnesty.ie/wp-content/uploads/2016/04/Amnesty-International-Government-Spending-on-Mental-Health.pdf>.

⁹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14.

The national mental health policy also recognises that some individuals with mental health difficulties who are homeless will require long-term rehabilitation support:

“While first contact with the mental health services may be through a mental health service for [homeless people], a proportion of individuals will benefit from transfer to a rehabilitation service.”¹⁰

A Vision for Change also set out specific recommendations to ensure the housing needs of people with mental health difficulties are met, including:

- The implementation of the Action Plan on Homelessness and reinforcement of the statutory responsibility of housing authorities in this area (Recommendation 15.2.3)
- A range of suitable, affordable housing options to be made available to prevent the mentally ill [sic] becoming homeless. Local authorities must fulfil their obligations under the Housing Act to provide housing to people in their area who require it (Recommendation 15.2.4)
- CMHTs should adopt practices to help prevent service users becoming homeless, such as guidelines for the discharge of people from psychiatric in-patient care and an assessment of housing need/living circumstances for all people referred to mental health services (Recommendation 15.2.6)
- Integration and coordination between statutory and voluntary housing bodies and mental health services at catchment area level should be encouraged. Continued support by mental health services for individuals in securing their tenancy should be maintained (Recommendation 15.2.7)

Connecting for Life, the national suicide prevention strategy also includes commitments to reduce suicidal behaviour and improve mental health among priority groups, including members of the homeless community.

In December 2014, the Department of Environment, Community and Local Government developed a 20 Point Action Plan on Homelessness. This plan included commitments to ensure in-reach mental health services into all emergency accommodation settings across the Dublin Region and to implement a formal discharge protocol with Dublin hospitals and homeless services to ensure that, as far as possible, no patient will be discharged into homelessness.

More recently, in its Operational Plan, 2016, the HSE Mental Health Division committed to extending specialist services for homeless people with mental health difficulties in Dublin and other cities.

Preventing homelessness among people with mental health difficulties

The right to adequate housing is also recognized in international human rights law as part of the right to an adequate standard of living. There are a number of human rights instruments that include obligations on state parties to ensure this right is enjoyed. Of particular importance is Article 25 (1) of the Universal Declaration of Human Rights (UDHR) and the ICESCR which states that “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... housing ...”

The Convention on the Rights of Persons with Disabilities further endorses this right and it

requires States to “promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including their right to adequate housing”.¹¹

There is general recognition at international level that people with disabilities (including people with mental health difficulties) experience many barriers in accessing secure and appropriate accommodation and are at increased risk of homelessness and inadequate housing. Such barriers include:

- Ongoing discrimination and stigmatisation
- Institutional hurdles
- Lack of access to the labour market
- Low income
- Lack of social housing or community support
- Lack of security of tenure

The right to housing is reflected to varying extents in Irish policy. Policy and standards that reflect Ireland's intention to meet the housing needs of people with severe and enduring mental health difficulties, including individuals who are at risk of becoming homeless, include:

- *A Vision for Change*
- *The Housing Strategy for People with Disabilities 2011-2016*

- *Rebuilding Ireland: An Action Plan for Housing and Homelessness*¹²
- The Mental Health Commission's *Code of Practice on Admission, Transfer and Discharge from an Approved Centre*¹³
- HSE guidance paper *Addressing the Housing Needs of People Using Mental Health Services*¹⁴

It is clear that both international human rights law and Irish policy support the provision of good quality mental health services to people experiencing homelessness, as well as services and supports to prevent homelessness among people with mental health difficulties.

11 Article 1 requires States to promote respect for their inherent dignity. Article 9 further demands that States adopt measures to identify and eliminate obstacles and barriers to accessibility, notably in relation to housing.

Article 12 recognizes that persons with disabilities enjoy legal capacity on an equal basis with others and requires States to take appropriate measures to enable persons with disabilities to exercise legal capacity. Article 28 recognizes the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate housing, and demands that States take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability, for instance by ensuring that persons with disabilities have access to public housing programmes.

12 Government of Ireland (2016) *Rebuilding Ireland: An Action Plan for Housing and Homelessness*, available at <http://rebuildingireland.ie/>.

13 Mental Health Commission (2009) *Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre*, Dublin: Mental Health Commission.

14 HSE (2012) *Addressing the Housing Needs of People using Mental Health Services: A Guidance Paper*, available at www.hse.ie/eng/services/Publications/Mentalhealth/housingdocument.pdf.

Methodology

Introduction

This chapter provides an overview of the methodology and methods employed in this study. It includes information about the study's overall objectives and research design, data collection methods, recruitment of participants, sampling, and data analysis. Ethical considerations for the study are also addressed.

Aim and objectives

The aim of this study was to document Dublin Simon Community clients' stories of seeking help for their mental health difficulty and their own explanations of how this relates to being homeless.

The objectives of this study were to:

- Describe homeless people's experiences of mental health difficulties
- Describe homeless people's experiences of seeking help for their mental health
- Describe homeless people's perspective on the relationship between their mental health, mental health treatment and their experience of homelessness
- Identify barriers to homeless people accessing and sustaining mental health treatment

Study design

The study design utilised for this project was Participatory Action Research (PAR). PAR is an approach to research that combines participatory research processes with action to effect social change. PAR therefore draws on two traditions in research: 1) participatory research which seeks to democratise the research process and 2) action research which seeks to combine theory generation with action to effect social change

(Khanlou and Peter 2005). In the case of this project, PAR offered the potential to valorise the subjective experience-based knowledge of homeless people and to use this knowledge as the basis for action to change the mental health system in the direction of more user-friendly services. Phase one of the project, which is the focus of this report, consisted of participatory research with clients of Dublin Simon Community. The second phase of the project is action-orientated collective advocacy training with participants to learn how to engage in campaigning for better mental health services; the third phase of the project is action to engage in a public campaign for better mental health services.

In order to implement the participatory approach inherent to PAR study designs, this study was conducted in partnership with Dublin Simon Community and Dublin Simon Community's CAG¹⁵. During a CAG monthly meeting, the researcher briefed the attending CAG members about the study and their potential involvement and roles. They were asked to think about their involvement and to then contact the researcher to confirm their participation. A total of six CAG members confirmed their commitment to the project; becoming the Client Advisory Group (AG), and attended a one day training event. Although many of the AG members had previous experience of undertaking research studies and were consequently already aware of ethical issues, the one day training consolidated their previous knowledge and ensured all AG members were fully cognisant of their role in this project. Following the one day training event, a meeting was held and the participating AG members were advised on the appropriateness of the study design and the study materials. After a

15 The CAG comprises of past service users of Dublin Simon Community who were once homeless.

group discussion, the researcher and AG members agreed on the appropriate terminology to be used and the approach taken to verbally explain the study to potential participants as well as the concepts of voluntary participation and informed consent. The AG's guidance on these issues was also incorporated into the written information sheet and consent form. The AG was also involved in promoting the study with the researcher and provided verification of data analysis, which will be further outlined in the relevant sections of this chapter.

Data collection methods

Qualitative data collection methods were utilised alongside the overarching study design of PAR. Qualitative research, unlike quantitative studies, does not work from a predisposed set of hypotheses but instead allows and enables the emergence of alternative or surprising evidence. Its strengths therefore include its exploratory capacity, flexibility, and emphasis on the subjective experience of the participant, including their interpretation and meaning of events.¹⁶ In this vein, the data collection tools used in this study were one-to-one and group interviews, which both facilitate in depth insight into people's unique experiences, and their perceptions, and understandings of same. In addition, the explicit facilitation of group interaction and discussion fostered in group interviews produces valuable comparative and contrasting data and insights¹⁷, as well as providing rich, concentrated data on a specific topic.

In this study, data collection encompassed:

1) one-to-one semi-structured interviews with Dublin Simon service users who have/had mental health difficulties; and 2) group interviews with Dublin Simon staff members. The rationale for having group interviews with Dublin Simon staff members was two-fold. Firstly, with a small number of client interviews being conducted, the group interviews with staff helped to widen the range of experiences brought to the study, adding examples of situations from staff members' experiences of client pathways. Secondly, staff contributed their own perspective, adding new interpretations to the study based on their experiences of seeking to provide support to their clients. In this way, the group interviews with staff served both to 'triangulate' or corroborate the client findings and also to complement client findings with an analysis based on staff experiences.

The one-to-one and group interviews were semi-structured in order to foster their exploratory capacity and thus allow the emergence of surprising and unanticipated findings, but also to ensure the aims and objectives of the study were satisfied and to provide a common framework across all data sources.

16 Sarantakos, S. (2012), *Social Research*, London: Palgrave Macmillan.

17 Morgan, D.L., (1996) *Focus Groups*, *Annual Review of Sociology*, 22, 129-152.

Study sample and recruitment procedures

One-to-one interviews with service users

Service user participants were recruited from Dublin Simon Community's client base. A variety of recruitment strategies were employed. In the first instance, posters advertising the study were placed on notice boards within Dublin Simon Community residences. The poster included a brief summary of the research, the inclusion/exclusion criteria for participants and the contact details of the researcher.

In addition to the poster campaign, the researcher and members of the AG verbally promoted the study in six of Dublin Simon's residences, and other Dublin Simon services (e.g. outreach support group and community engagement scheme group). The researcher and available AG members attended the beginning of group sessions or monthly residents' meetings in each of the residences and explained the purpose of the study, the data collection procedures, the potential advantages and disadvantages of participation, the ethical issues of voluntary participation, informed consent, and confidentiality. Written information (i.e. the study poster and a participant information leaflet) were also disseminated to all those in attendance. Individuals were asked to study the written material over the following week and to contact the researcher directly if they had any questions and/or to register their interest in participating. To further facilitate convenience in registering their interest, individuals were also given the option of notifying their Dublin Simon key worker, who in turn facilitated the organisation of

the interview with the researcher.

Further to the outlined recruitment strategies, the study was also promoted by Dublin Simon Community's Client Involvement Officer who in the course of her work disseminated written and verbal information about the study at various meetings and events.

After considerable recruitment efforts over a prolonged period of time from September 2015 to March 2016 (approx. 7 months), 10 people agreed to be interviewed.

Further demographic information on the 10 service user participants is outlined in Table 1.

Group interviews with staff members

In March 2016, an open invitation via email was disseminated to Dublin Simon Community's staff members. The email included a brief explanation of the study and their potential participation. A participant information sheet providing further comprehensive information about the study was also attached to the email. Interested participants were asked to contact the researcher directly. Consequently, potential participants were given time (approximately one week) to consider if they wished to take part after which the researcher contacted them again to confirm their willingness to participate and check their availability to attend a group interview. In the event, two group interviews were conducted: one comprised 2 participants and a second comprised a further 3. Further information on the 5 staff member participants is outlined in Table 1.

Table 1. Participant Profiles

Service User Participants	Gender	Age	Years of Housing Instability¹⁸
1	Female	55-60	30+ years
2	Male	65-70	30+ years
3	Female	65-70	10 years
4	Male	60-65	12 years
5	Male	55-60	8 years
6	Male	45-50	15 years
7	Male	60-65	25 years
8	Male	30-35	4 years
9	Male	25-30	8 years
10	Male	30-35	10 years
Staff Member Participants	Gender	Occupation in Dublin Simon Community	
1	Male	Project Worker – Respite/Stabilisation	
2	Male	Project Worker – Long term Residence	
3	Female	Projects worker – Support to Live Independently	
4	Female	Project Worker – Recovery	
5	Female	Project Worker – Emergency Shelter	

Interview process

Interviews with service user participants were conducted in a meeting room in their Dublin Simon residence. Group interviews were conducted in Trinity College Dublin. Immediately prior to the commencement of both the one-to-one and group interviews, the researcher provided a brief introduction about the study, its purpose, and the specific topics under discussion, before obtaining written informed consent from participants. The interviews were then initiated by the researcher asking the opening question on the interview guide (Appendix I and II).

The duration of one-to-one interviews with service users ranged from 35-90 minutes. The group interviews with staff members lasted approximately 60 minutes.

Data analysis

Interviews were recorded and transcribed by a Mental Health Reform staff member. Data from the interviews was analysed using thematic analysis¹⁹. Data was analysed firstly through a process of open coding. Individual transcripts

18 During this time of housing instability, participants fluctuated between periods of rough sleeping and residential mobility (i.e. living in Dublin Simon or other similar residences, living in rented accommodation for short periods and/or living with friends/family).

19 Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), 7-101.

were read numerous times and open codes identified and condensed into general themes. Open codes were examined and a process of axial coding was conducted to identify the relationships and connections between themes, as well as the conditions which gave rise to these occurrences, including context, interactions and consequences. Once complete, codes for individual interviews were subsequently compared, with minor modifications made to include data of relevance to the topic, but which was not necessarily discussed by all participants. This process provided repeated opportunities for the researcher to cross-check the raw data against emergent themes; therefore ensuring analytical development was robust, rigorous and trustworthy. An initial draft of the analysis was provided to Dr. Shari McDaid and Professor Agnes Higgins and their feedback was subsequently incorporated into the final draft of the study's findings.

Validation of study findings

In order to validate the study's findings, a member checking process was conducted. Member checking is often thought to be integral to demonstrating credibility as it enables the participants to confirm/disconfirm the researcher's interpretation of data (Creswell and Miller, 2000). The service users' interview transcripts were returned to them, along with a request to contact the researcher if they felt their words/ideas were not represented accurately in the transcript. An audio copy of their interview was also included with the written transcript to assist participants with limited literacy skills. The researcher also followed up with participants to verbally clarify the member checking process and encourage participants' engagement with it. In addition, the study's findings, as interpreted by the researcher, were also presented to a meeting of the AG members for validation. The core study

findings and relevant questions designed to elicit their feedback were informally discussed with AG members and field notes were taken. During the discussion, the AG consistently confirmed the researchers' analysis of the data garnered from the service user participants (see Advisory Group Feedback on Findings below).

Recruitment challenges

The originally proposed target sample size for the one-to-one interviews with clients of Dublin Simon Community was between 15-20 participants. However, despite varied recruitment efforts and an extended recruitment period, a lower than anticipated sample of 10 participants was secured. In order to further explore the reasons for the low rate of participation, the Dublin Simon staff member group interview participants and the AG members were invited to provide their appraisals as to why more people did not come forward to participate.

One of the most prominent reasons suggested by both Dublin Simon staff members and the AG was that this targeted cohort of participants may be justifiably cynical of the research process. It was considered that the cynicism or apathy towards research in this cohort may originate from their previous experiences of being involved in research projects, or other initiatives, which resulted in few, if any, tangible changes or improvements in services. As one Dublin Simon staff member participant suggested, people may have thought "not again" or "more people coming asking questions but nothing ever changes". The researcher therefore appraised that the commitment to action inherent in the PAR study design of this research may have impacted little upon the targeted cohort's motivation to participate.

A second reason suggested by Dublin Simon

staff members and one which AG members identified from day one of the research study during their training day and again after the completion of the research was that of the continuing stigma attached to mental health difficulties. AG members felt that potential participants may have been struggling to name their experiences as mental health difficulties due to the associated stigma. A view was also expressed that people may have been reluctant to come forward to participate for fear of people finding out about their mental health problems. Dublin Simon staff members also re-iterated these concerns and added that in their experience, clients with enduring mental health difficulties are in most cases reluctant to openly talk about them.

Dublin Simon staff member participants and AG members also identified additional features of the research and its devised implementation which may have hindered participation. For example, although some felt that the researcher being an outsider to Dublin Simon Community and thus unfamiliar to potential participants may have been an advantage to some potential participants, it may also have served as an additional barrier to other people participating. Similarly, the requirement to conduct the interview in a Dublin Simon residence may have been perceived as favourable by some but not by others. In addition, limited literacy skills were also suggested as a potential barrier to some people participating. Dublin Simon staff and AG members appraised that some people may not have fully understood what was involved in the research and consequently were reluctant to ask for more information for fear of disclosing their literacy difficulties. Lastly, it was also felt that some people may have been intimidated by the research process and lacked confidence in their ability to participate and/or add anything of value to the research.

Ethical considerations

Ethical approval for this study was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. All participants were provided with both written and verbal information about the study which specifically outlined study procedures, the risks and benefits to taking part, and the protocols associated with confidentiality, voluntary participation, and the protection of participants' wellbeing.

Prior to every interview, the researcher verbally reiterated to all participants that their participation was voluntary and they could choose not to answer any question if they so wished, or to stop the interview and/or withdraw from the study at any stage. Access to Dublin Simon Community's counselling service was also available to service users in the eventuality that they became upset or distressed during the course of their participation in the study. This support was not availed of by any of the participants. However, during one of the one-to-one interviews a participant became visibly uncomfortable while sharing their experiences. The researcher reminded the service user that their wellbeing was of upmost importance and that they could take a break and recommence the interview at a later stage or withdraw from the study if they so wished. The participant decided to finish the interview and remained happy for it to be included in the study. The service user also linked in with his Dublin Simon key worker after the interview.

Participants were also verbally assured that their confidentiality was strictly protected at all stages and that all data files were password protected and stored in accordance with the Data Protection (Amendment) Act 2003. At the end of all the interviews, the researcher

spent time ensuring that all the participants felt comfortable with how the discussion went and their participation in it.

Study limitations

This was an exploratory qualitative study. As such, the findings of this study must be considered in light of a number of limitations:

- The study findings are drawn from the narratives of a small, heterogeneous sample (n=10) potentially limiting the generalisability of the results and inhibiting the identification of additional factors which may influence homeless people's experience of mental health services
- As is the case in all research, participants relied on autobiographical memory in the re-telling of their stories. The retrieval of memories can be a difficult endeavour, influenced by many factors including stress, the endurance of trauma and the experience of psychological difficulties, which can result in the formation of partial, fragmented or indeed entirely unspoken narratives. The study's reliance on participants' autobiographical memory may therefore have impacted the findings
- The researcher's identity (a white, middle class, educated woman) and the power differential between the researcher and some of the participants may have influenced the content of participants' narratives as well as the analysis of same
- Similarly, the power differential between participants, gatekeepers, and the researcher may have limited participants' latitude to provide voluntary informed consent. Participants may have viewed gatekeepers and the author as authority figures and consequently felt obligated to participate

Study findings

Introduction

Study findings garnered from a qualitative descriptive analysis of the 15 participants' narratives (10 service users and 5 staff members) are presented in three themes. These are 1) A complex web; 2) Barriers to help seeking; and 3) Successful pathways to improved well-being. The first theme, entitled 'A complex web', examines the various interdependent factors which, participants surmised, contributed to the onset and/or exacerbation of mental health difficulties amongst people who have experience of homelessness. In the second theme, 'Barriers to help-seeking', the various systemic and psycho-social factors informing participants' motivation and ability to access mental health supports are explored. Finally, the third theme, 'Successful pathways to improved wellbeing' focuses on some of the successful pathways to mental health supports that service users encountered, in addition to staff members' recommendations of future important initiatives needed to address the mental health difficulties of people who experience homelessness.

Section A:

A complex web: homelessness, mental health difficulties and addiction

The service users' narratives/stories/ experience suggested that there was a complex, interdependent relationship between their mental health, their experiences of homelessness, and, for some, their addiction difficulties. While in most cases, one of these difficulties appeared to have initially influenced the onset of another (e.g. mental health difficulties leading to homelessness or vice versa) service user's descriptions suggested that once in motion, a non-linear and interdependent relationship occurred between their mental health, and their experiences of addiction and homelessness, with each contributing to the subsequent onset and/or exacerbation of the other. However underpinning this complex web in all of the service user participants' narratives was their early endurance of a traumatic event. For many of the service users, their varied experiences of trauma strongly informed the subsequent events and actions they took in their lives. In the following sections, each of the components to this complex web are explored.

The role of trauma

The majority of service users (n=8) either directly spoke about, or in the very least alluded to, experiencing some form of trauma in their past, particularly in their childhood and adolescent years. For some, their experience of trauma resulted from the sudden deaths of loved ones, and the subsequent onset of an immense and very difficult bereavement process:

"It was like they were all dropping one by one. Like they were getting shot, [or] it was from cocaine or [tragic accidents]²⁰." (Participant 9, Male)

However for others, their experience of trauma also stemmed from their endurance of emotional, physical, and sexual abuse. These participants described the detrimental effect such experiences of abuse had on them and how they struggled to cope in their aftermath. Their difficulties in overcoming such trauma had, for the majority of service users remained with them to the present day:

"I suppose, for me, this all started for me from when I was about thirteen yunno but I won't go into that part of it. It was really sort of really, really had me up the wall like yunno". (Participant 10, Male)

"I don't mind saying this because I'm getting counselling, but I was getting abused at school. It wasn't by teachers, it was a complete stranger, but he had such a hold over me, and maybe to this day still a bit, but I'm going [to a] counsellor and that. Now I'm okay talking about it, I'm grand. So those issues were going on for me when I was thirteen." (Participant 7, Male)

From service user's perspectives, their past experiences of abuse and/or the loss of loved ones was the backdrop or the context within which many of them began to experience mental health difficulties and/or experiment with substance use:

"Ah the mental health difficulties, cos they were going back since I was twelve, the abuse and all that. I didn't even know what the word 'abuse' meant at the time, so it would have been really that first. Then when the alcohol came along, I was in me teens, fourteen/fifteen, just to me, it made me sick, but it was just a magic thing, take that and it gets rid of all those feelings It gets rid of all these feelings, it blocks out everything yeah,

20 In order to protect the identity of the participant, the details of the tragic accident referred to, which was publicly and prolifically reported on, are omitted.

that was for me it blocks out any, if anything happened.” (Participant 7, Male)

“When it happened when I was young, then I was smoking cannabis first. And then I start selling it and then cocaine came along and then I start selling that. And then the weekend we probably do some of that. It wouldn’t be much yunno but we’d do some in the parties there and things were popping up that was reminding me of things and I just didn’t want to know.” (Participant 9, Male) .

and find a, so they got me, into the [name of supported accommodation]. And I moved from there to here [a second supported accommodation residence].” (Participant 5, Male)

Participants recalled that living independently had become too challenging for them as they aged:

“No, I couldn’t live independently now. No, I wouldn’t survive.” (Participant 5, Male)

Mental health difficulties leading to homelessness

In a number of cases (n=4), it was service user’s mental health difficulties which had induced their experiences of homelessness. Their numerous hospital admissions, which occurred repeatedly over several years and for prolonged periods of time, severely compromised their ability to sustain employment and secure stable accommodation. These participants, all of whom were in retirement age, noted that they consequentially experienced decades of living in unstable, temporary accommodation in between their hospital admissions:

“I ended up in back lanes, in the Ivy [homeless hostel accommodation]. I had flats here and there for a while and just really going in and out of hospitals.” (Participant 2, Male)

For this cohort of older aged participants, their enduring mental health difficulties and a recurring cycle of hospital admissions and subsequent hospital discharges to unstable, temporary accommodation eventually led to their permanent placement within supported accommodation:

This was particularly the case for those living in shared living accommodation wherein the age and needs profiles of the growing number of residents were increasingly diverse:

“[...] people is coming in an, and asking me for sugar, milk, bread and everything and have ye got a lend of a fiver until Wednesday, I said ‘I haven’t got it, so don’t be banging me door’ [...]” (Participant 1, Female)

“The first two years in the [name of accommodation] was very nice. But after that, it went downhill an awful lot. The women there, I’m not saying anything, wasn’t as respectful as me and some of the men, wasn’t respectable either. As I’m aware of myself, I am a respectable girl and I was brought up respectable. Now my two nurses from Inchicore, [nurse 1 name] and [nurse 2 name] said to me I was too much of a lady to be in the [name of accommodation], because [interviewer name], there was 120 there.” (Participant 3, Female)

“And I was only homeless once in hospital. The landlord wanted me out. So I had to go

The psychological impact of being homeless

With the backdrop of past trauma in mind, service users recounted that their subsequent experience of homelessness and the stressors which being homeless induced, also contributed to either the onset of new or an exacerbation of existing mental health difficulties. From their perspectives, homelessness induced a profound sense of loneliness and abandonment. They recalled feeling like nobody cared for them as very few had sustained positive relationships with former friends and family:

“But ye know I have been in some low places where you do feel like you have nobody, loneliest person on earth like. Homelessness as well has a big part to play in it, you do feel like very low when you’re on them streets, you really do like.” (Participant 8, Male)

“You wake up in the mornings and you’re on your own. God, I hate it, hate it. [...] I’d wake up in the mornings crying. I mean, how could that be? I’d wake up crying!” [...] (Participant 6, Male)

“Feel lost like, ye know? [...], you feel like your family doesn’t want ye, and nobody else wants you either, ye know? You’re left on the street like.” (Participant 8, Male)

In addition to the service user’s feelings of abandonment and loneliness, they recounted the innumerable stressors which encompassed the experience of being homeless. These stressors ranged from trying to find emergency accommodation, to managing hostile environments in hostels or on the street. Participants recalled that their days would be filled with exhaustive levels of worry and anxiety,

leading to panic attacks and in some cases thoughts of suicide:

“It takes its toll on your brain like, it really does like, wears you out [...] especially when you’re sleeping in these places where there’s four people to a room and stuff like that, yunno? You could have like, an addict in one corner, alcoholic in another corner, a chap that’s probably sober in that corner, and somebody with a serious mental illness in the other corner like, yunno? It’s a volatile situation like yunno what I mean? It’s not a nice situation to be in [...]” (Participant 8, Male)

“Sometimes when I lie down it takes me four/five hours just to get asleep thinking about it. And the dreams I’m having like, they’re like real. I close me eyes and I’m jumping in me sleep. And sometimes I’d wake up, in a panic attack.” (Participant 9, Male)

“I reckon within a couple of months I’ll be probably dead. It’s a better, in my mind I’d rather, I don’t want to be going the way it’s going. I’m ducking and diving like from no-one.” (Participant 9, Male)

The narratives of the Dublin Simon staff members supported the accounts provided by the service users in this regard. They too conveyed the immense stressors encompassing being homeless and the detrimental effect this had on service users’ mental health. In particular, the uncertainty for their clients of not knowing firstly where they would sleep that night and secondly what they may encounter if they did access a hostel, was perceived to be extremely stressful and psychologically challenging for their clients:

"The lack of stability [...] They're ringing the freephone, they're calling in the morning, they're told to call back in the afternoon, if there is still no beds they're told to call back at half ten at night and they just don't know what's happening and to expect anyone to focus or keep themselves safe within that it's extremely challenging." (Staff member participant 4, Female)

"The uncertainty and then what goes with being on the street or emergency accommodation; the violence, the aggression, the drug taking the, just that sense of what's coming? what's next?". (Staff member participant 3, Female)

As the preceding quote indicates, staff members articulated that service users were particularly susceptible to experiencing trauma in hostel accommodation due to sharing a room with four strangers and seeing or hearing certain unsettling behaviour from other service users:

"Trauma for sure, like [...] go into a room where we don't know another 4 people and spending the night in there and you don't know what everyone else's needs are or backgrounds That in itself is completely traumatic even if you're not directly exposed to seeing anybody using or doing anything or being aggressive." (Staff member participant 4, Female)

"Hearing things even, hearing things through walls can be so unsettling." (Staff member participant 3, Female)

Consequently, the often hostile and traumatic environment in hostel accommodation was surmised by staff as being a breeding ground for stress for service users, but also for staff members who struggled to adequately manage with staff shortages:

"The buildings, the actual buildings create and contribute it seeps through the walls of these walls [...] they're short staffed, they're staffed very poorly so they cannot be managed and that is a very real issues like because the staff are really stressed as well, [it's a] breeding ground for stress." (Staff member participant 1, Male)

"I've one client and he was just talking about how it's etched in his memory a body bag being taking out of the hostel, you know it's just like, if you're in that environment ... " Interviewer." it's just a fertiliser for mental health difficulties really."
"Yea exactly yea." (Staff member participant 3, Female)

Self-medication

For many of the service users, addiction difficulties played a significant role either in the onset of their becoming homeless or as a consequence of becoming homeless. Whichever the causal direction, both service user and staff members recounted that drugs and/or alcohol were often used in an effort to alleviate mental distress, to forget past trauma and to numb the deleterious realities of being homeless. From this perspective, drugs and/or alcohol offered relief from the constant, painful and exhaustive anxiety and distress:

"In many cases they would be using one substance or another to try to mitigate the symptoms of their mental health and to feel somewhat ok." (Staff member participant 2, Male)

"Where before I let these issues of loneliness come up, a bit of depression creep in, could have been anxiety creep in, as I was getting a drink just to get over that, to block it all out." (Service user participant 7, Male).

"Looking back on it, I think the drug use was, me heroin use was basically me antidepressants, yunno what I mean? [...] That's the one that took all me worries away, yunno? Instantly, yunno? So I took it, yunno? But it was good and it took the stress off me shoulders and stuff like that." (Service user participant 8, Male).

As the above quote alludes to, some of the service users directly articulated that their substance use was a form of self-medication. As will be discussed later, some of these participants had experienced little benefit from previously engaging with mental health services or supports and with few alternatives, turned to illicit drugs as a solution to their distress:

"The depression was before the drugs even started like. I took antidepressants first as I told ye, I took them for about six months or something like that and I was taking them one day, and not the next and I think at the end of that then, we're not gonna say I came straight off the antidepressants and I went straight onto the heroin but the heroin was after the antidepressants so maybe it was down to I was still depressed. I thought I was better, and I wasn't really, yunno? As I said, self-medicating with heroin like, yunno?" (Service user participant 8, Male).

However, service users admitted that their self-medication was a temporary fix which often subsequently led to an exacerbation of their distress, particularly if events had occurred while they were on drugs which they later deeply regretted and/or struggled to cope with:

"[...] I didn't care as long as, it was basically just to make me feel better [...] if I was to sit there sober, I'd be sitting there constant thinking and worrying and maybe be crying

if I was on my own. It was really like, as you said the quick fix, got all the pain away and made me alright for them couple of hours. But then it turned around and when I hadn't got it, made me sick, So it wasn't really fixing me, it was just making me worse." (Service user participant 8, Male).

"Doing things and going into the house and causing rows and yunno things like that, yunno and I'd be guilty. And it wouldn't hit ye, this guilt doesn't hit ye, until you come off all the drugs and all that. Then it starts hitting ye." (Service user participant 9, Male).

Feeling hopeless

While most of the service users said that they now felt their mental health had improved, mainly due being in secure accommodation at the time and engaging with counselling and other mental health supports, there was a cohort of service users who remained completely depleted and demoralised as a result of both their past and present circumstances. These participants noted that their mental health remained extremely fragile as they struggled to find permanent accommodation and to get their life back on track:

"Doing all I can but it's not enough, it's not enough, it's not. But there's no more I can do. I'm worn out. I literally am worn out." (Service user participant 8, Male).

Similarly, others were feeling demoralised that despite their continued efforts, their mental health difficulties were not improving:

"But like I'm five years trying to face up with everything, I even done the counselling. I don't know anymore. I really don't." (Service user participant 9, Male).

"I've felt very lonely here and I find myself very isolated here and I don't know whether I'll stay here. I have to stay to try and get well and I don't know how long I'll be. I'd say I'll have to stay, I want to go back to the (accommodation name) but I moved on so much when things are, I run soon as I get somewhere I like, I can't settle, I keep running away from myself."
(Service user participant 2, Male).

Service users' feelings of being demoralised were also expressed by some of the staff members who recounted that they found it extremely difficult to convey hope to service users since the onset of the recession and the consequential ongoing housing crisis. Staff members felt that in pre-recession times, when there was a reasonable probability of re-housing, they were able to communicate and provide a clear pathway to service users to avail of these opportunities. However, in the current economic and housing climate, their ability to instil hope and motivation and therefore manage service users' anxiety regarding the uncertainty of the future was severely compromised:

"The staff could communicate that hope, it's harder to communicate that hope now, it's hard because there isn't, because you're like, We do groups like and you're in the group and they're like where am I going to go next like? What am I going to do? And you're like [deep in breath] and you have to bring them down to simple goals, simple things break it down but it's hard to communicate hope you know."
(Staff member participant 1, Male)

"It's that sense of you do this but where do you go now you know, what happens afterwards. I think back a few years ago before the crash there was a sense of hope, that there was a continuum of care if you follow

this model you have a chance like you know."
(Staff member participant 1, Male)

"Back in the day if someone prove themselves to go through detox, and then rehab addressing their issues and stay on the short and narrow then the council and the homeless services were quite accommodating after they could get the more long term beds but the last couple of years, the last 5 years nearly I think, Freephone and what only if you're lucky or referral right out onto the streets." (Staff member participant 2, Male)

Such pervasive uncertainty about service users' futures not only resulted in demoralisation among service users but it also had a detrimental impact on many of the staff members. They disclosed that at times they felt they were actively misleading clients by encouraging them to apply for housing and to go to house viewings despite the high probability that they would almost certainly experience disappointment:

"You definitely feel like you're misleading them and almost just pushing them to at some point experience failure and that is very hard to do because then you are managing everything that comes with it and seeing someone that was motivated to work on things and all of a sudden that setback puts them back and it's extremely hard to almost be the one that evokes that and that is your role in it but it is very hard to take [...]" (Staff member participant 4, Female)

Section B:

Barriers to help-seeking

Both service users and staff members identified significant barriers to homeless people accessing and maintaining continued and consistent support for their mental health difficulties. Such barriers were both systemic and psycho-social, with participants citing bureaucratic procedures, feeling stigmatised, and prior negative experiences as reasons for their limited and difficult engagement with mental health services. Those who did successfully access sustained mental health support highlighted that this only occurred through the facilitation of Dublin Simon Community. These barriers are further outlined below.

Bureaucratic system

Both service users and staff members described the administrative challenges in accessing some services as a result of homelessness. Specifically, the issue of catchment areas was highlighted. Service users noted that without an address it was extremely difficult to access some mental health services and at times they were turned away:

*"It is A&E because once I *inaudible* and 'where you living?' I says 'I live on the streets' yunno and my sister was sitting beside me and jaysus, she couldn't believe it. They said 'well we can't do nothing for ye, we need an address for ye' [...]" (Service user participant 10, Male)*

One service user noted that in the absence of a current address, people were often advised to go back to the services in the catchment area of their last address. However, for many homeless people this induces further cumbersome barriers to seeking help, including but not limited to the expense of travel to that area. Furthermore, for some of the service users, St Brendan's hospital was their former source of reliable mental health support and its closure has resulted in them now

having to endure the difficult negotiation of new services from scratch:

"But just getting there, with no home, I probably wouldn't, the reason why I got to [service name] was because I have an address in [name of residence]. So I was in the catchment area. Cos if you're homeless, you've no catchment area, have ye? You have to go back to your last one. My last one would have been Brendan's, but Brendan's is gone now. So I don't know. They'd probably say, go into A&E in Mater or something. You're going back through the whole process." (Service user participant 7, Male)

Similarly, in addition to the difficulties resulting from the imposition of catchment areas, some of the service user participants also noted that without a medical card, they experienced difficulties in accessing support. In the case of the participant cited below, he felt that without a medical card, he was refused access to care:

"When you're on the streets, you didn't have a medical card, they didn't want to know ye, they didn't want this, it was so weird it was. They didn't want to know nothing like, yunno. If you have a medical card, you've a possibility of a chance like. [...] You don't have a medical card, couldn't care less like yunno, here's a prescription, go in, get out of here like." (Service user participant 10, Male)

Being stigmatised

An additional and significant barrier noted by many of the service users was their feeling of being stigmatised by hospital staff when attempting to access services. A number of service users stated that they often felt uncomfortable and under surveillance when attending services. They also felt that that other

service users and staff members watched them with disapproval:

“Particularly if you’re homeless, you may look dishevelled, you may not smell too good, and if they smell drink off ye at all, they’ll label you straight away. You might have only have had a couple of beers, just to build up the courage to even go in and say ‘look, I want to see a psychiatrist’. You’re sitting there in the waiting room and you have someone or the security guard standing beside ye or a care assistant or a nurse or whatever, people are looking and saying, ‘what’s going on with this person? Is he a troublemaker?’ So yet again, there’s other people kind of watching ye. You go out to have a cigarette and the security person is following ye out, there beside ye. People do look. So there is a label.” (Service user participant 7, Male)

Some of the service users said that they felt their reasons for attending the service were questioned. They believed their mental health needs were overlooked by a common misperception that they were only attending in an effort to access shelter and a bed for the night. Instead of receiving a validation of their mental health needs, service users recalled that they subsequently weren’t provided with the same quality of care as other service users:

“When I was homeless, yeah. They just see, maybe not them all, maybe I’m wrong saying everyone, but the majority I’ve met, they just see the homeless person and they do smell the drink off ye. If you were drunk obviously, security will be calling you out, that’s fine, I can understand that but they just don’t see past, they just see that you’re homeless, they don’t give you the same. Cos to me, I think if I was sent up there today with stomach pains it would be a different story. I think it would be.

It would be yunno? I would give my address. Complete different story.” (Service user participant 7, Male)

“You go to A&E after taking an overdose or whatever, especially if you’re homeless, straight away you’re gone. He’s only looking for a bed, He’s only looking for a bed like, yunno what I mean?” (Service user participant 10, Male)

Service users’ difficulties in this regard were validated by staff members who described the often onerous effort required on their part to ensure that their clients accessed an A&E assessment bed for just one night:

“There has been good cases too where I’ve advocated for people in A& E and get them into an assessment bed for the night, it has happened but it takes bull to tear down the wall sometimes.” (Staff member participant 2, Male)

Negative prior experience

While the administrative procedures and stigmatisation were significant barriers to participants accessing mental health supports, one of the strongest barriers cited by service users was their previous negative experiences with mental health or counselling services. In most cases, negative experiences were, from the perspective of participants, due to not receiving adequate and appropriate support. Participants described feeling like their mental health needs were discounted or not taken seriously enough, as they were often speedily discharged with no outpatient supports:

“I threw myself in the canal. I actually tried to drown myself in the canal I did like, yunno and I was brought to Vincent’s hospital.

And I was in Vincent's hospital like yunno and was there for a few hours and all of a sudden, psychiatrist comes along and yeah, yeah he was asking me if I thought I was depressed, and if I wanted to be dead and blah, blah, blah, blah, blah and 'okay, now you can go home'. Ha ha, oh what the hell, this is totally mad, it was really totally crazy like yunno? Me thinking, different hospital might turn around and give me the extra help that I was looking for. But no I didn't, I didn't get it. I suppose the same would have went for the Mater Hospital as well, didn't get it there either like yunno?"(Service user participant 10, Male)

"But eventually, yeah it happened one time in Galway, em a really, really bad way, I was down there sleeping rough then three or four weeks. And I was seeing the doctor down there and she said 'the psychiatrist' is very busy, I said 'well I'll wait'. She said 'there's no point in waiting you better go back to Dublin'. I said 'oh god alright', and I walked out." (Service user participant 7, Male).

The participant cited in the preceding quotation disclosed numerous similar incidents from different hospitals over a considerable duration of time, indicating that during each of his attempts to access services he received little consideration, engagement and support for his mental health difficulties. Such was the effect of not being taken seriously that participants became discouraged with services and discontinued their attempts to seek help. One service user however recalled that he knew of others who self-harmed in a desperate attempt for their mental health needs to be given adequate attention by the services when they attended:

"Most of the lads I know over the years,

*would say the same. They wouldn't go, especially on the street [...] and they'd say 'I'm not going to that place at all' and sometimes some people cut themselves, they just kind of have to, have to cut meself just so they'll listen. Now that was a horrible thing *inaudible* I have to cut meself, for them to take notice. [...] I know some people who have done it just to walk up and say I cut meself, and you don't have to explain anymore." (Service user participant 7, Male).*

"I suppose the more I went to James' hospital, it got to the stage that I was like 'fuck the hospitals' like yunno what I mean?" (Service user participant 10, Male).

Conversely, for some service users it was not until after they had successfully navigated access to support that they experienced negative interactions with mental health professionals. One participant recalled that his trust in counsellors had been left devastated when a counsellor, in whom he had confided a past trauma, discontinued their appointments without notice or explanation. The participant described how this had had a lasting effect on him as he felt abandoned by the counsellor and left to cope alone with a trauma he had long buried. As a result of such a negative outcome, he believed he could never trust another counsellor in the future:

"[...] I would never trust a counsellor again I wouldn't. [...] I was coming up to the end of a year and a half seeing him and [...] all I got was a letter saying apologies that he would never be here again. So I was left with something I'd buried for so long and that was brought back up and I was left with that again. So I was taking more and more panic attacks then. Like I could have kept that to myself for another fifteen/sixteen years [...]"

that was it, so ever since then I wouldn't even trust another counsellor. I've said no to loads, and the result of that is that I'm suffering now." (Service user participant 9, Male).

For another of the service users, counselling had been too distressing an experience to return to as he found that having to repeatedly disclose and reiterate painful experiences was too overwhelming at that time. After finally breaking down in one of the sessions, he never returned again:

"Back then I was on the antidepressants, I actually was seeing a counsellor and I went in one day and I broke down. It was too much around that time, yunno what I mean? I left that day and I never went back like, yunno? It was just getting too much for a while, yunno like. Going every week and having to speak about it. It was hurtful, to talk about it, yunno? All the stuff that was going on, yunno? But I end up leaving that, and I never went back to anything I didn't like it yunno, never went to counselling again." (Service user participant 8, Male).

For a number of the older participants however it was their prior experiences of being prescribed psychotropic medications that influenced their reluctance to continue to engage with mental health services. Participants recalled times where they felt they had been given the wrong type or had been over-prescribed medication, which resulted in them feeling worse. As illustrated in the quotes below, participants described their preference to talk to someone about their difficulties instead of taking medications:

*"Oh my head was just scrambled as in they were giving me all sorts of psychotic drugs *inaudible*, Haldol, shock treatments, and looking back I didn't need those. I know now*

I didn't need them, but at the time they thought, I didn't need all that. I didn't need them. But they thought this was gonna do okay, they were professionals, so I'll take that tablet, and really I just needed someone to sit down and talk to." (Service user participant 7, Male)

"But I never should have got involved in psychiatry. I know people walking these streets who have problems and they wouldn't go near a psychiatrist. The last person they would go to is a psychiatrist cos they just mess up your life, they give you mind-altering drugs and then that's what they gave me. [...] Yunno, mind-altering drugs, you cannot do that to people. You don't give a person mind-altering drugs, you talk to them. And you get to the root of the problem. But they don't have the time they tell you." (Service user participant 2, Male)

Dual diagnosis

The service users who had experience of both mental health and addiction difficulties described additional challenges when trying to access support for their mental health. They said that in many of the services they accessed, the detection of substance use triggered their immediate removal from mental health services into those for addiction difficulties:

"There is that whole dual-diagnosis. I know loads of them, so they will filter you off somewhere else if they think that they smell drink on you, even during the interview, 'how much do you drink? Do you take tablets?' That's it, you're gone. That's the problem." (Service user participant 7, Male).

"The other thing that happened to me, if I was having a few drinks going in, taking

tablets, same thing they just look at ye and do your bloods, and do your urines, whatever else they have to do, oh I see you've taken this, you've taken that. Yunno most of them say come back in sober the next day, and you just don't want to come back the next day." (Service user participant 10, Male).

The service users' experiences in this regard were reiterated by the staff members who also noted that it was often very difficult for service users to access mental health supports while still struggling with their substance difficulties. In their experience, the presence of substance use resulted in their clients' ineligibility to access mental health services:

"They want it to be clear cut mental health so go home and deal with your cannabis or whatever it is , drink, first and come back then in a couple of months before they even look at the referral." (Staff member participant 1, Male)

One staff member identified that access to mental health services was still denied even in crisis situations where a service user is expressing suicidal thoughts but where there is also evidence of substance use:

"One thing I find difficult to deal [with] while we're in the emergency accommodation is if we do have a client that is expressing suicidal ideation if the client is affected in any sort of way, we call the guards or ambulance if they are feeling suicidal yet because there is an active substance they're not willing to actually take them, they can't so even within the mental health act it is difficult to get that kind of support." (Staff member participant 4, Female)

A significant consequence of dual diagnosis and consequential ineligibility to access mental health services was that service users' mental health needs were left unaddressed. A number of service users noted that even after considerable treatment for their addiction difficulties, their underlying mental health difficulties remained and were a significant factor in their relapse:

"You get treated for that drug addiction, but that mental health is not looked at, yunno?" (Service user participant 8, Male).

"I remember they took me into hospital six up in James' and me thinking 'yeah, they're actually doing something now'. But when I figured out what they were doing, was they were only detoxing me. Yunno and it was a week later, they thrown me back out. [...] my sister pleaded with them to keep me in there, but they decided I wasn't mad enough." (Service user participant 10, Male).

"I think most people just think it's the tablets and the drink. They don't realise that there's issues there. And then when they go in somewhere like a drink detox, a rehab unit, a lot of people go out and they slip, and they're back again, because they haven't dealt with what's going on." (Service user participant 7, Male).

Section C:

Successful pathways to improved wellbeing

The barriers mentioned above resulted in service users finding access to appropriate mental health supports as extremely challenging. However, a number of the service users also noted that successful pathways to support had been forged for them by Dublin Simon Community. A significant number of these participants noted that it was only through their relationship with Dublin Simon Community services that their access to consistent, reliable, and appropriate mental health supports was eventually unlocked. The below quotations from participants illustrate the role Dublin Simon services played in facilitating access to mental health supports:

“She got me in contact with the psychiatrist up in Park Hall and I suppose from then onwards, was pretty okay. The influence of other people like that would have an effect on the psychiatrist and things like that; I suppose gobsmailed me because they actually listened to me this time, like yunno what I mean? [...] they made a difference because Dublin Simon put me towards this person like, yunno what I mean.” (Service user participant 10, Male).

As a result, many of the service users felt indebted to Dublin Simon for facilitating their access to mental health support from which they experienced great benefit:

“I suppose only for Dublin Simon I wouldn’t be here as I am today, I suppose if I look at it that way really carefully like, because only for them, like I would have never got introduced to the access team up in [service name] up the road yunno and they worked with me for over a year, maybe even a bit longer.” (Service user participant 10, Male).

For staff members, it was not only access to appropriate services that were needed to address

the mental health difficulties of their clients. They also consistently noted the integral role that secure, permanent housing played in facilitating service users’ ability to improve their mental wellbeing:

“For mental health, people have to have a safe and stable environment you know, and that’s sort of comes down to accommodation that’s stable and long term support.” (Staff member participant 1, Male)

“[...] I think its dry accommodation as well stable accommodation, just better accommodation that secure base because there is just so much post-traumatic stress that’s brought in by the homelessness.” (Staff member participant 3, Female)

Many of the staff members felt that without this security of housing tenure, it was extremely difficult, if not impossible, for service users to address their mental health difficulties. The excerpt below from one of the staff members illustrates the extensive barrier being homeless can be on a service users’ ability to fully engage with mental health supports:

“That uncertainty [of accommodation] is a block to even fully engage, I have clients and they don’t want to open up, they go ‘I know I need to talk about x,y, and z but I don’t want to because I can’t go back on the street softened if you know what I mean I need to stay har.” (Staff member participant 3, Female)

However, staff members were also adamant that the key to improved well-being for people who experienced homeless was not only stable, secure housing but continued long term support. Many of the staff members recounted how they had often witnessed service users secure

permanent housing but subsequently lose it again a few months later:

“They sort of destruct, they create a situation so it breaks down, so they’re back, it happens a lot actually, it’s just that self-sabotage thing it happens a lot yea [...] just terrified.” (Staff member participant 1, Male)

Staff members explained that this often occurred because service users who had been homeless and lived in various short term homeless accommodation for a long time struggled to live independently as they had, in some respects, become institutionalised and consequently completely dependent on the homeless services:

“I think when people find themselves in their own apartment and they’re faced with themselves its very frightening...that’s institutionalisation and comes down to what you’re used to

When they access emergency accommodation they have 24/7 hour support and it’s from being on the streets or having very little support to having a full team of like from nurse to counselling to everything and referrals to everywhere yet all of a sudden they are again on their own [...]” (Staff member participant 4, Female)

Consequently, staff members felt it was vital that support services actively encouraged coping and life skills while service users remained in emergency accommodation and that such supports remained long after people received the keys to long term, secure housing:

“[...] it’s very important that while they are in emergency accommodation that we do enable them coping skills to develop or improve.” (Staff member participant 4, Female)

“So it’s trying to say getting the house, getting the keys is not the end, life will keep on going.” (Staff member participant 3, Female)

It was also noted by one staff member that immediate accessibility to mental health support services was paramount to ensuring homeless people received mental health support when they needed it. For him, the ideal service was one which was able to immediately capitalise on the times when service users were motivated to seek supports. In order to do so, he felt a specialised service designed to simultaneously care for clients with dual diagnosis which operated an open door policy, and was located in an accessible and inconspicuous location was required:

“You have to strike while the iron is hot and if someone is interested it helps if there is an accessible service then and there, and so consistency and all like that and openness so people can come when it suits and a location where there are not necessarily seen where they are going, some level of secrecy around it and where I suppose trained professionals who can deal with mental health addiction or the two of them together.” (Staff member participant 2, Male)

Summary conclusion

The study findings highlight the many complex and inter-dependent factors which contribute not only to the onset and/or exacerbation of mental health difficulties for people who experience homelessness but also to their ability to recover and manage such challenges. While the cohort of service user participants was split between those who experienced mental health difficulties prior to becoming homeless and those who experienced mental health difficulties subsequent to becoming homeless, it was clear from both set of service user narratives that experiencing unstable and temporary housing conditions had significant detrimental influences on both their mental health and their ability to recover. For some of the service users, such destructive stimuli influenced the onset of their addiction difficulties, which added a further layer of complexity and trauma to their existing mental health problems. Both service user and staff member participants also reported that difficulties accessing appropriate mental health supports added further frustration and distress and served as an additional barrier to initiating and/or sustaining recovery. While service users highlighted the integral role that Dublin Simon Community played in facilitating easier access to much needed support services, Dublin Simon staff member participants reported the need to: 1) improve access to current mental health services; 2) establish combined support services for people with a dual diagnosis of mental health and addiction difficulties and; 3) ensure the availability of continued, long term supports for people after they are independently housed. However, the primary need to firstly increase the availability of safe, secure and permanent housing was deemed vital to the success of such service interventions. This was also reported by staff members as essential to facilitating service users' sustained recovery.

Advisory Group feedback on findings

As described in the methodology chapter, draft findings were presented to a meeting of the client Advisory Group for validation. Their reflections on the findings are worth reporting because they provide additional insights on the research topic.

With regards to 'A complex web', the first of three themes presented, AG members expressed that the multiple factors identified as potential contributors to the onset and/or exacerbation of mental health difficulties amongst people who have experience of homelessness were accurate and that the representation of the described factors as complex and interdependent was also appropriate.

The terminology/phrases utilised by AG members to convey their confirmation of the analysis in this theme included "it's [experiencing multiple stressors] like being on a merry go round" "bang on", "on the button", "fair reflection", "demoralisation is the perfect word", "that [demoralisation] would be very common", "it could be called multi-complex web".

Despite their confirmation of the analysis presented in 'A complex web', AG members were also surprised that other factors, such as discrimination against homeless people, the criminalisation of homeless people and family history of mental health problems were not mentioned by participants as contributors to their mental health difficulties.

AG members also confirmed the analysis presented under the theme of 'Barriers to help-seeking'. In particular, the experiences recounted in the sub-themes of 'feeling stigmatised' and 'prior negative experiences' resonated with the AG's own personal experiences. The AG members felt that the participants' struggles

to receive quality services were not isolated to the mental health services but were also felt by people with experience of homelessness in other sectors such as education, hostel accommodation, and employment. The AG members also astutely identified that some of the barriers identified by participants were not specific to people with experience of homelessness and could equally be experienced by other members of the general public. Similar to their surmising of 'A complex web', AG members again identified other barriers (e.g. financial, waiting lists, limited provision of mental health services across the board, lack of awareness of where or how to look for support) which were not mentioned by some of the participants. Specifically, they expected that the stigma attached to mental health would have been identified by participants as a barrier which hindered their accessing of mental health services. However, on discussion there was consensus that the fact that stigma was not identified by participants as a barrier may have been due to low participation in the study among those clients who would have felt fear of being stigmatised by participating.

Lastly, the AG expressed their agreement with the researcher's interpretations of the data included in 'Pathways to Improved Wellbeing'. AG members confirmed the importance of access to safe housing with security of tenure in facilitating improved mental health and wellbeing for people with experience of homelessness. They also echoed the participants' appraisals that long term supports after re-housing were integral to sustaining wellbeing.

However, AG members added that long term support initiatives, such as SLI (Supported Living Independently) and befriending projects, currently existed and provided valuable support to many people. However in order for them to

induce tangible results and improved outcomes, increased funding was required. AG members also echoed staff member participants' sentiments in relation to the need to combat the institutional effects of long term supported accommodation living by actively promoting life skills within this environment. It was felt that doing so would assist people to transition successfully to independent living and help minimise relapse and/or the breakdown of housing placements.

The AG members also engaged in a lively discussion as to whether future action should focus on the development of specialist mental health services for people with experience of homelessness or whether the improved accessibility of mental health services for all members of society would suffice. Despite the divergence of opinion on the direction of future action, there was strong agreement with the sentiment expressed by one AG member; "to be part of the answer, you must have experience of the problem".

Discussion

This study sought to describe the trajectory of homeless people's interactions with mental health care. Using ten in-depth interviews with people who are or have been homeless as well as two small group interviews with homeless agency staff, the study sought to uncover and document, mental health stories from the perspective of homeless people themselves. While the research is small, it serves to fill an important gap in the Irish evidence base by illustrating in depth the types of pathways that lead to poor mental health among homeless people and the barriers that inhibit them from attaining their human right to the highest attainable standard of mental health. Adopting a participatory approach and foregrounding the voices of homeless people themselves is also an ethical and empowering mode of research practice in keeping with the recovery ethos for mental health services.

The study findings reiterate the now well-established interdependent and deleterious relationship between homelessness, the endurance of complex trauma, mental health difficulties, and substance use.^{21,22} In the first instance, many of the participants recalled their endurance of trauma in their past, particularly in their childhood and adolescent years. Participants disclosed that the struggle to cope with and overcome such trauma, which included multiple bereavements, and/or emotional, physical, and sexual abuse, remained with them to the present day. Participants' narratives in this regard are indicative of an established relationship between the endurance of trauma

and the experience of homelessness and substance use. It is widely understood that early developmental trauma, including child abuse, neglect, and disrupted attachment, provides a subtext for the narrative of many people's pathways to homelessness²³ and that there is a strong link between the endurance of multiple forms of trauma (coined complex trauma) to substance use, heightened suicide risk, mental health difficulties, lack of trust in relationships, and difficulty creating stable conditions (such as employment or housing).²⁴

Furthermore, the experience of being homeless, including the hostile environments of rough sleeping and/or emergency and short term housing solutions, significantly contribute to a deterioration in participants' mental health. Many studies published previously have identified this same causal relationship noting that the stressful circumstances experienced during homelessness increase the presence of mental health symptomatology^{25,26,27} and, experienced cumulatively, can have traumatogenic effects. Similarly, the participants' descriptions of the volatile relationship between substance use and mental health difficulties are also consistently demonstrated within previously published literature where dual diagnosis has been

21 Coates, J. and McKenzie-Mohr, S. (2010) *Out of the frying pan, into the fire: Trauma in the lives of homeless youth prior to and during homelessness*. Journal of Sociology and Social Welfare, 37(4), 65-96.

22 Hopper E. K., Bassuk E. L., and Olivet, J. (2010) *Shelter from the storm: Trauma-informed care in homelessness services settings*. The Open Health Services and Policy Journal, 3(2), 80-100.

23 Ibid.

24 McKenzie-Mohr, S., Coates, J., and McLeod, H. (2012) *Responding to the needs of youth who are homeless: Calling for politicized trauma-informed intervention*. Children and Youth Services Review, 34(1), 136-143.

25 Fitzpatrick, K. M., LaGory, M., and Ritchey, F. (2003). *Factors associated with health-compromising behavior among the homeless*. Journal Of Health Care For The Poor And Underserved, 14 (1), 70-86.

26 Fitzpatrick, K. M., and LaGory, M. (2011). *Unhealthy cities: Poverty, race, and place in America*. New York: Routledge.

27 Irwin, J., LaGory, M., Ritchey, F., and Fitzpatrick, K. M. (2008). *Social assets and mental distress among the homeless: Exploring the roles of social support and other forms of social capital on depression*. Social Science and Medicine, 67 (12), 1935-1943.

proven to evoke increased psychiatric symptoms and suicide risk as well as an increased risk of re-hospitalisations, and relapse, and reduced compliance with treatment^{28, 29,30,31}.

Participants' experiences of trying to access mental health support were often frustrating. They recalled that accessing mainstream primary and tertiary mental health services was an adverse experience marred by administrative bureaucracy, stigma, disrespect and lack of service co-ordination. As a result of such challenges, some of the participants recounted how they utilised hospital emergency departments as a last resort, a trend which is also evident in previously published studies^{32,33}. However even when attending hospital Emergency Departments they felt that they yet again did not receive the therapeutic support that they very needed. The deficits in providing accessible mental health care for homeless persons with mental health conditions, identified by participants in this study, have also been widely acknowledged and

documented elsewhere³⁴. So too, the distinct challenges in accessing mental health care that the cohort of participants with dual diagnosis in this study identified also reiterate findings from other studies.³⁵ Participants' narratives in this regard provide evidence of the detrimental outcomes that can occur because of the parallel treatment approach that currently operates in Ireland wherein substance abuse services and psychiatric treatment programs are entirely disconnected, with different funding streams, training and philosophical approaches to treatment. In such systems, individuals must go to one service for mental health support and another for substance abuse treatment. As described by participants in this study, the operation of parallel services for mental health and substance use not only acts as an additional barrier to accessing appropriate and timely support it also fails to take into account the interactive and cyclical nature of dual diagnosis.³⁶ Further, prior research suggests that service user outcomes in parallel treatment systems are generally poor.³⁷

In addition, many of the service users said that their experience of being homeless had either induced or exacerbated their mental health difficulties. This finding when considered in conjunction with the staff members' beliefs that access to housing would help to alleviate the mental health difficulties of people experiencing

28 Archie, S., and Gyomory, K. (2009). *First episode psychosis, substance abuse and prognosis: A systematic review*. Current Psychiatry Reviews, 5(3), 153–163.

29 Schmidt, L. M., Hesse, M., and Lykke, J. (2011). *The impact of substance use disorders on the course of schizophrenia—a 15-year follow-up study: dual diagnosis over 15 years*. Schizophrenia Research, 130(1–3), 228–233.

30 Soyka, M. et al. (2001). *Psychopathology in dual diagnosis and non-addicted schizophrenics—are there differences?* European Archives of Psychiatry and Clinical Neuroscience, 251(5), 232–238.

31 Zammit, S. et al (2008) *Effects of cannabis use on outcomes of psychotic disorders: Systematic review*. The British Journal of Psychiatry, 193(5), 357–363.

32 Kushel, M. et al (2002) *Emergency department use among the homeless and marginally housed: Results from a community-based study*. American Journal of Public Health, 92(5), 778–784.

33 Chambers, C. et al (2013) *High utilizers of emergency health services in a population-based cohort of homeless adults*. American Journal of Public Health, 103(S2), S302–S310.

34 Canavan R. et al. (2012) *Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities*. BMC Health Services Research, 12(1), 222.

35 Priester M. A. et al (2016) *Treatment access barriers and disparities among individuals with co-occurring mental health and substance use disorders: An integrative literature review*. Journal of Substance Abuse Treatment, 61, 47–59.

36 Mueser, K. T. (2003) *Integrated treatment for dual disorders: A guide to effective practice*. Guilford Press: New York.

37 Drake R. E. et al. (2001) *Implementing dual diagnosis services for clients with severe mental illness*. Psychiatric Services, 52(4), 469–476.

homelessness, would strongly suggest that access to quality housing with security of tenure will be essential to ensuring the successful recovery of people with experience of both mental health difficulties and homelessness. Staff members in particular believed that without security of housing tenure, it was extremely difficult, if not impossible, for service users to address their mental health difficulties. Previous research has also strongly demonstrated that the capacity to recover from mental health difficulties is severely compromised by the instability of homelessness.³⁸

Prior research indicates that the provision of Housing First³⁹ has been shown to decrease psychiatric symptoms, including depression and alcohol related problems^{40, 41, 42} and attenuated suicidality⁴³. However, housing interventions like 'Housing First' have been proven to do little to appease the rates of substance use amongst

homeless populations. Somers et al (2016)⁴⁴ found that Housing First did not reduce daily substance use compared with treatment as usual after 12 or 24 months. In addition, reflecting the narratives of the staff members in this study, there is also a general consensus across the breadth of prior research that housing alone will not guarantee recovery and that easy access to long term support services are integral to sustaining recovery⁴⁵.

In this vein, previously published studies have demonstrated that fragmented responses within each of the sectors (i.e. homelessness, mental health, substance use) will do little to quell the deficits in care provision described by participants in this study. Instead, single-entry point and co-located and/or integrated assessment, treatment, and case management services are increasingly recognised as the key components of increasing treatment access among this vulnerable population^{46,47, 48}. In recognising this, other jurisdictions have implemented integrated services for people who experience homelessness, mental health difficulties and substance use and in so doing have facilitated enhanced access to treatment and participation, reductions in substance

38 Macnaughton, E. et al. (2016) How does Housing First catalyze recovery?: *Qualitative findings from a Canadian multi-site randomized controlled trial*. American Journal of Psychiatric Rehabilitation, 19(2), 136-159.

39 Permanent, low-barrier, non-abstinence based housing specifically designed to support the recovery of homeless people who have co-occurring mental illness and substance use disorders).

40 Collins, S.E. et al. (2012). *Project-based Housing First for chronically homeless individuals with alcohol problems: Within-subjects analyses of two-year alcohol-use trajectories*. American Journal of Public Health, 102(3), 511-519.

41 Greenwood, R. M., et al. (2005) *Decreasing psychiatric symptoms by increasing choice in services for adults with histories of homelessness*. American Journal of Community Psychology, 36(3), 223-238.

42 Stergiopoulos, V. et al. (2015) *Effectiveness of Housing First with intensive case management in an ethnically diverse sample of homeless adults with mental illness: A randomized controlled trial*. PLoS ONE 10(7): e0130281. doi: 10.1371/journal.pone.0130281.

43 Collins S. E. et al. (2016) *Suicidality among chronically homeless people with alcohol problems attenuates following exposure to Housing First. Suicide and Life-threatening Behavior*, doi:10.1111/sltb.12250.

44 Somers J. M., Moniruzzaman, A., and Palepu, A. (2015) *Changes in daily substance use among people experiencing homelessness and mental illness: 24 month outcomes following randomization to Housing First or usual care*. Addiction, 110(10), 1605-1614.

45 Gaetz, S., Scott, F., and Gulliver, T. (2013) *Housing First in Canada: Supporting communities to end homelessness*. Canadian Homelessness Research Network Press: Toronto.

46 Drake, R. E. et al. (2004) *Evolving U.S. service model for patients with severe mental illness and co-occurring substance use disorder*. Acta Neuropsychiatrica, 16(1), 36-40.

47 Kola, L. A., and Kruszynski, R. (2010) *Adapting the integrated dual-disorder treatment model for addiction services*. Alcoholism Treatment Quarterly, 28(4), 437-450.

48 Minkoff, K. (2014). *Best practices: Developing standards of care for individuals with co-occurring psychiatric and substance use disorders*. Psychiatric Services, 62(5), 597-599.

use, more days in stable housing, and greater reductions in psychiatric hospitalisation and arrests⁴⁹. Building on the success of such integrated services, some jurisdictions have moved towards improving accessibility even more by implementing integrated services in conjunction with Assertive Community Treatment (ACT), resulting in similar beneficial outcomes including enhanced initial and ongoing engagement in the dually diagnosed⁵⁰. The establishment of integrated services would also assist in alleviating what participants in this study identified as a knowledge deficit amongst health professionals regarding dual diagnosis. Several studies have also indicated that there is a lack of capacity to identify and/or give adequate credence to a dual diagnosis of substance use and mental health disorders among medical, mental health, and substance abuse service providers^{51,52, 53,54}. Adams (2008)⁵⁵, alongside Richmond and Foster (2003)⁵⁶, found that insufficient knowledge of dual

diagnosis was associated with negative attitudes towards patients with dual diagnosis. Given that professionals' attitudes towards working with dual diagnosis are important the training needs of staff in this regard would be particularly pertinent to address.

The study findings also highlighted service users' prior negative experiences when attempting to seek support in a variety of health care settings, including mental health services, and how such interactions later informed their reluctance to return and/or consistently engage with mental health supports. They indicated that they consistently felt their needs and opinions were devalued and disregarded. Such experiences, which are also voiced by other people who have utilised the mental health services,^{57,58} provides further evidence that traditional approaches to mental health care and treatment in Ireland, which are often cited as being paternalistic and professionally-dominated, continue to predominate. There must therefore be continued efforts to strive towards embedding a more respectful and empowering approach to mental health care in all our health care supports and services. The implementation of a recovery oriented approach, recommended in national policy since 2006,⁵⁹ is one way through which mental health services in Ireland have been striving to achieve this much needed change in ethos. The recovery approach is considered to comprise eight core principles. These include: 1) having optimism and hope about recovery; 2) valuing the person's voice and personal meaning; 3) respecting personhood and

49 Dixon, L.B, et al. (2010) *The 2009 schizophrenia PORT psychosocial treatment recommendations and summary statements*. Schizophrenia Bulletin, 36(1), 48-70.

50 Cooper R. L. et al. (2010) *Outcomes of integrated assertive community treatment for homeless consumers with co-occurring disorders*. Journal of Dual Diagnosis, 6(2), 152-170.

51 Blumenthal, D. et al. (2001). *Preparedness for clinical practice: Reports of graduating residents at academic health centers*. Journal of the American Medical Association, 286(9), 1027-1034.

52 Carey, K. B. et al. (2000). *Treating substance abuse in the context of severe and persistent mental illness: Clinicians perspectives*. Journal of Substance Abuse Treatment, 19(2), 189-198.

53 Foster, S. et al. (2010). Services and supports for individuals with co-occurring disorders and long-term homelessness. The Journal of Behavioral Health Services & Research, 37(2), 239-251.

54 Pinderup, P. (2016) *Training Changes Professionals' Attitudes Towards Dual Diagnosis*. International Journal of Mental Health and Addiction, doi:10.1007/s11469-016-9649-3

55 Adams, M. W. (2008). *Comorbidity of mental health and substance misuse problems: a review of workers' reported attitudes and perceptions*. Journal of Psychiatric and Mental Health Nursing, 15(2), 101-108.

56 Richmond, I., and Foster, J. (2003). *Negative attitudes towards people with co-morbid mental health and substance misuse problems: an investigation of mental health professionals*. Journal of Mental Health, 12(4), 393-403.

57 Keogh B. 2011. 'Managing Preconceived Expectations' Mental health service users Experiences of Going Home from Hospital: A Grounded Theory Study. Unpublished Doctorate Thesis. Trinity College Dublin.

58 Watts M. 2012. Recovery from 'Mental Illness' as a Re-Enchantment with Life: A Narrative Study. Unpublished Doctorate Thesis, Trinity College Dublin.

59 A Vision for Change: Report of the Expert Group on Mental Health Policy (2006), Dublin: The Stationery Office.

uniqueness; 4) mobilising the person's own resources; 5) supporting partnerships between peer networks and mental health services; 6) respecting expertise by experience; 7) enabling meaningful participation and inclusion and; 8) respecting and embracing multiple perspectives.⁶⁰ In light of these eight core principles, Mental Health Reform argues that there are five key building blocks to successfully practicing a recovery orientated approach, 1) partnership, 2) listening, 3) hope, 4) choice and 5) social inclusion, which if implemented correctly would result in clients feeling listened to, respected, valued and included in all decisions regarding their care options.⁶¹ The realisation of such laudable principles and practices is however a challenging endeavour for many traditionally-framed mental health services. Consequentially, the implementation of the recovery approach has been slow and inconsistent⁶² and as this study shows, many clients of the mental health service continue to report disempowering interactions. It is therefore integral that the cultural and structural changes required for successful implementation, as outlined in Mental Health Reform's position paper '*Recovery...what you should expect from a good quality mental health service*⁶³, are adequately resourced and facilitated. It is equally important that all stakeholders vested in the recovery approach's successful implementation continue to work together to ensure that that "*the principle of recovery set out in A Vision for Change become*

realised in the day-to-day response to mental health in Ireland"⁶⁴.

The successes of integrated services in other jurisdictions and/or the consistent implementation of the recovery approach in Irish mental health services notwithstanding, Hopper et al. (2010, p.81)⁶⁵ state that "We will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness". Given the findings of this study, and other studies which corroborate its findings and outline the pervasiveness of traumatic stress among people who experience homelessness, the need to ensure effective Trauma-Informed Care (TIC) within homeless services settings must also be considered. Internationally, TIC is increasingly advocated for in homeless services with research findings indicating that it is:

- 1) Well-received by consumers and providers
- 2) Appears to lead to better outcomes than treatment as usual (including an improvement in consumers' daily functioning and a decrease in trauma symptoms, substance use, and mental health symptoms)
- 3) Decreases the use of intensive services such as hospitalization and crisis intervention and
- 4) Does not cost significantly more than treatment as usual^{66,67}

60 Higgins, A. (2008) A Recovery Approach within the Irish Mental Health Service: A Framework for Development. Dublin, Mental Health Commission.

61 Recovery...what you should expect from a good quality mental health service. Mental Health Reform. <https://www.mentalhealthreform.ie/wp-content/uploads/2013/03/MHR-Recovery-paper-final-April-2013.pdf>.

62 Higgins A. & McGowan P. (2014) Recovery and the recovery ethos: challenges and possibilities. In Mental Health in Ireland; Policy, Practice and Law. (Higgins A. & McDaid S, eds.), Gill & Macmillan, Dublin, pp 61-78.

63 Op. Cit., fn 53.

64 Ibid., p.29.

65 Hopper, E. K., Bassuk, E. L. and Olivet, J. (2009) *Shelter from the storm: Trauma-informed care in homelessness services settings*. The Open Health Services and Policy Journal, 2, 131-151.

66 Op Cit., fn 48.

67 Op Cit., fn 13.

Despite these promising findings, the implementation of TIC within homelessness service settings is still in its infancy and with few established and comprehensively evaluated TIC programmes in place, the opportunities to easily replicate are limited. There are therefore some unanswered questions before implementing TIC for the homeless population including what exactly defines TIC, what changes should be made within systems wishing to offer TIC, and how these changes should be implemented. Consequently, it would be important to take the time to establish and strengthen support for TIC from administration, programme staff, and clients, while also ensuring adequate assessment and screening processes, the ongoing provision of staff training and supervision, and the inclusion of client consultation in TIC development and evaluation^{68,69,70}.

Therapeutic and programming recommendations are of course only possible with adequate funding and public and structural supports. While there has been an infusion of state funding directed into homeless services in recent years, such investment has been relatively offset by Ireland's current unprecedented level of homelessness. As a result, homeless services are primarily reactive and severely compromised in their capacity to respond to anything more than the basic needs of their clients. Mitigating the inducement of substantial increases in substance use and mental health difficulties which will inevitably arise from the unprecedented homelessness crisis, while simultaneously responding to those currently in need, will be extremely challenging. Given that most of the service users in this study described

Dublin Simon Community and its staff as vital for their pathway to mental health care, it would be important that the valuable advocacy and liaison work of homeless agencies is adequately acknowledged and resourced commensurately.

As outlined in the policy section of this report, the visibility acknowledgement of the needs of people with mental health difficulties who are homeless and/or are in need of housing supports in the current Irish policy framework is encouraging. However, despite their visibility in policy documentation to date, the development of mental health services for homeless people was not a priority in the first nine years of the implementation of *A Vision for Change*. Future improvements will therefore require enhanced efforts to promote accountability and ensure policy commitments are translated into practice. There is also a need to review the policy on homeless mental health in *A Vision for Change*⁷¹ which in its current form does not reflect either the current extent of homelessness nationwide or the more recent evidence on good practice in relevant supports. For example, the policy on division of services between dual diagnosis and mental health clearly needs to be reviewed. The scale of specialist mental health support for homeless people also needs to be significantly higher than what was originally outlined and envisaged in *A Vision for Change*.⁷²

68 Op Cit., fn 48.

69 Op Cit., fn 13.

70 Wong, C. F., Clark, L. F. and Marlotte L. (2016) The impact of specific and complex trauma on the mental health of homeless youth. *Journal of Interpersonal Violence*, 31(5), 831-854.

71 Op Cit., fn. 51.

72 Ibid.

Next steps

While this study has highlighted some of the pathways into homelessness for people with a severe mental health difficulty and shown some of the ongoing challenges they face in accessing adequate mental health support, it remains for the next two phases of the project to take up this evidence and use it to campaign for change.

The upcoming review of Ireland's mental health policy provides an opportunity to provide a stronger policy framework for mental health service provision that promotes mental health among homeless people and prevents homelessness among people who have mental health difficulties. It will also be important that in implementing its *Action Plan for Housing and Homelessness*, the Government supports better access to mental health services for people experiencing homelessness and adequate access to housing for people with severe mental health difficulties who have a housing need.

With the support of the St. Stephen's Green Trust, Mental Health Reform will work in partnership with Dublin Simon Community during 2017 and 2018 on the *Homeless Adults Speak Out on Mental Health* campaign for better mental health service provision. The second phase of the project, collective advocacy training with people who have experienced homelessness, began in August 2016 and will continue in 2017. Participants will also engage in a public campaign for better mental health services with the support of Mental Health Reform and Dublin Simon Community. Participants have already received a briefing on the research findings and are planning their campaign strategy and communication strategy. One action in this campaign will be the group's response to this research and their participation in the launch of this report. The follow-on campaign will provide an opportunity for people with experience of homelessness and the agencies who support

them to hold public health and housing services to account for delivery of their commitments under Irish policy and international law and to demand better services. In the context not only of the research findings but also of the current surge in homelessness, such focussed attention is more urgent than ever.

Response by the Homeless Adults Speak Out on Mental Health Group

Introduction

We, the Homeless Adults Speak Out on Mental Health Group are participants in Mental Health Reform and Dublin Simon Community's project on mental health and homelessness, as set out at the beginning of the report. The group is made up mostly of Dublin Simon clients, including people with experience of both homelessness and mental health difficulties. Over the last few months we have been working together to write this response to the report on *Homelessness and Mental Health: Voices of Experience*. While there are many problems for people who are homeless in getting the mental health support that they need, when they need it, we are going to focus on two really important issues. These are in line with our priority campaign issues in advocating for better mental health services and supports for homeless people in Ireland.

1. Problems for homeless people in getting direct access to crisis mental health support on a 24/7 basis
2. Problems for homeless people who have both an addiction and mental health difficulty in getting the right supports

24/7 crisis mental health services

From the experiences of our group members we would like to highlight a number of problems for homeless people in getting access to mental health supports outside of normal working hours. That includes evenings, nights/early mornings and weekends.

The first problem is that there is very little or no staff working in community mental health services out of hours. That means that homeless people usually have to go to A+E if they are in crisis. However we think that this is not a practical solution. Most homeless people feel that if they go

to A+E they'll be worse off psychologically. Most homeless people won't go to A+E in the first place because they know how they're going to be treated.

Second, a lot of staff don't know how to work with people who are homeless and are not aware of the particular issues and challenges that face homeless people. When it comes to working with this group of people you have to have a certain kind of understanding, a decency, you have to be able to have a bit of compassion. But in our experience if you go into hospital you're not going to get any compassion or humanity.

Staff in A+E also don't seem to realise that homeless people can be victims of crime. If someone comes in and they're covered in blood they think he's scruffy, you homeless person, he must have been drinking, but you could have been beaten up.

Third, homeless people are not going to wait the long hours that people often have to wait in A+E. You might have to wait 6 or 7 or 8 hours. The attitude homeless people experience from staff is that you should have waited, you should have waited another few hours, you could be schizophrenic or anything.

One reason that homeless people are not going to wait so long is that there is quite a timetable with being homeless, when it comes to food services and the free phone service. By the time you'll be seen, you'll be gone. The staff in A+E don't seem to be aware of those kinds of things.

Fourth, the stigma that homeless people face when they go to A+E by staff and other patients is a big barrier to getting help and support. The way you're dressed is the way that people are going to judge you. If you're not dressed well people will look down on you. If you're homeless

of course you're not going to be dressed well. In our experience, the staff are the worst, if you look rough or mucky, or if you've been through a rough time or don't have the vocab they just think this is a scruffy.... When it comes to other patients some people class themselves as better than you and they make you feel worse than you did before you went in in the first place.

There are other problems with trying to get any mental health crisis support out of hours, including a lack of accountability and liability when homeless people are turned away or inappropriately discharged from the services, including A+E. There are big problems in getting access to supports because of catchment area boundaries as many homeless people will not be able to provide an address. There are no crisis houses across the country and no crisis outreach which would be really helpful to people who are homeless. There are problems getting access to GPs out of hours and there is poor follow on care after homeless people are discharged from A+E. There's no point taking someone into hospital and then as soon as they're okay throwing them back on the street because in a few weeks time they'll be back to square one.

Our group is putting forward a solution to this problem on lack of out of hours crisis care for homeless people. That solution is to develop and deliver 24/7 direct access to community mental health services for homeless people already engaged in the mental health services. It is important though, that it is not just doctors and nurses providing care but different types of professionals, for example counsellors. As well as that anyone that is providing supports should be trained in the particular challenges that face homeless people.

Overall, crisis care needs to be taken out of A+E. A+E is not a good place to be if you are

homeless and are experiencing a mental health crisis. You go there to get help, to share your problem and they'll just give you extra problems.

Dual diagnosis of addiction and mental health

When it comes to homeless people who have both an addiction and a mental health difficulty (aka dual diagnosis) there are added challenges in getting access to services and supports. This is a big problem as dual diagnosis is very common across the homeless community. If you are homeless or going to be homeless you are traumatised and end up drinking, using substances, leading to mental health difficulties. You feel alone, left out, rejected. That is what leads you to drink and/or take drugs.

One of the first and key challenges for homeless people in getting support for a dual diagnosis is the self-stigma, the double stigma. People don't want to say that they have a mental health difficulty, they don't want to say that they have an addiction, and they certainly don't want to say that they have both.

Second, where people do try to get help, they can't get access to mental health supports unless they are clean and sober. You drink because you are unwell and then you're labelled as a drunk or a junkie and you're turned away from the mental health services until you're sober.

Third, even if you were able to access the services, there are only a few good doctors who know about dual diagnosis. Mostly, doctors don't know about it. Doctors don't examine you properly, they don't ask enough questions. For those doctors who do work well with homeless people with a dual diagnosis it's so hard to find them or get access to them.

Fourth, in our experience if you present to A+E you are assessed differently depending on the hospital. You could go to one hospital and they will turn you away, just say that you're drunk, but if you go to another hospital they might admit you. They have the choice to say you're drunk, I'm not going to deal with you. That choice needs to be taken away. There should be a rule that you have to accept every patient. Ultimately, they've been given the power to discriminate and turn homeless people away. We need to change that power.

Fifth, it seems that staff aren't trained properly on the needs of homeless people who have a dual diagnosis. Training on dual diagnosis should be provided to staff in addiction services, homeless services and mental health services. It is important that staff are properly trained and educated on meeting the particular needs of individuals. For some people when they get sick they're the last to know they're sick. So if you present to a service and you're intoxicated and you can't communicate what's going on in your head the staff need to be able to cope with that.

It seems like there is no real understanding among staff of the particular issues that homeless people with a dual diagnosis face. If you are living in a hostel for example, you could be going back to a place where there is drink and drugs everywhere around you. You can be intimidated or tempted by other people and by the substances that they're using.

Sixth, homeless people who experience mental health difficulties are discharged from hospital and other mental health services way too quickly and in most cases without the proper aftercare in place. This is more so the case for homeless people with both an addiction and a mental health difficulty. There should be a discharge plan done for a minimum of 3 months to ensure that these issues are continuously addressed and proper

follow on care implemented. How is it possible to get better from mental health difficulties or dual diagnosis otherwise? If you come out of hospital and there's no follow on care you're not going to get better. People should also be made aware of other groups in the community that can provide support.

There are a number of other gaps for homeless people with a dual diagnosis in getting the supports that they need, including:

- Addiction and mental health services do not work together to improve supports for individuals
- Mis-diagnosis of dual diagnosis is common
- There is a lack of involvement of family members/carers and friends in dual diagnosis care. (This needs to be allowed with the permission of the person)
- The relationship between trauma and dual diagnosis and trauma, dual diagnosis and homelessness is not properly understood
- There is an over-use of doctors in working with people with dual diagnosis and not enough use of other professionals (e.g. counsellors). Specific training in dual diagnosis should be delivered to a range of different types of staff
- There is a lack of preventative measures to address dual diagnosis. Homeless people should be educated about mental health and offered support services such as counselling. In the Dublin Simon Counselling Service all the counsellors are free, there isn't enough good things to say about it. How do you get that service across the board? There should also be visiting support for homeless people, help with coping skills, things like that.

Overall, there is need for a 'no wrong door' approach so that no matter what service homeless people arrive at they will get the support that they need for a dual diagnosis. This might include referral, or it might involve one service providing some level of support with input from another. If you present to any hospital, homeless agency, addiction or mental health service they should be able to assess you and if appropriate transfer and accompany you to the right place where you will get the help that you need. This means that more training is needed for all services about dual diagnosis. For example, a service needs to be able to hold someone until they can talk (e.g. in an addiction service if you are detoxing) and then be able to work with or appropriately refer you on afterwards.

In conclusion it is not acceptable that there is such a lack of training and a lack of understanding of the mental health needs of homeless people across the services. It is not acceptable that there is so much stigma for homeless people in accessing mental health services and supports. It is not fair, right or just that homeless people cannot get the mental health supports that they need, when they need it. At a minimum we are looking for some kind of equity in the mental health services. The fact is that homeless people face greater challenges in getting the mental health supports that they need. It is nobody's fault if they become homeless. Nobody can control whether or not they're going to become homeless. It can affect anyone. We ask you what if it was you and not us. What if we were standing there where you are and you were standing here where we are?

Enough is enough, it is time that commitments to improve mental health services for homeless people were implemented. It is time that homeless people began to experience a real change, a better change.

Appendix I –

Client interview topic guide

1. Can you remember the first time you sought help for your mental health and what was happening during that time in your life?

2. Could you explain how you felt about the mental health support when you sought help?

Probes: Did you feel safe? Did you feel you were being looked after? Did you feel you had a say in your own treatment? Did you feel you had choices about your treatment? Did you feel the staff listened to your concerns? What were the staff like to talk to?

3. Did you experience any barriers to accessing mental health supports?

Probes: Did you have to wait for treatment? Did you get treatment when and where you first asked for it? If not, were reasons given to you about why you were not given treatment? Were you referred to another service provider?

4. Can you tell me about what kind of treatment you were or are getting and if you are happy with it?

Probes: Have you taken any medicine for your mental health difficulty? Have you gone to therapeutic sessions (e.g. counselling, group work, art,

music, recovery programmes)? Have you participated in any other supports for your mental health (GROW or other peer support group, wellness workshop, WRAP training, other rehabilitative training)

5. Is there anything about the mental health services that you would like to change?

Probes: the type of treatment? staff interaction?, who you talk to?, where it is? When it is available?

6. Do you think there is a relationship between your experience of accessing mental health supports and your experience of being homeless?

Probes: have mental health supports helped you to get out of being homeless? Have gaps in mental health support influenced your being homeless?

Appendix II -

Staff group interview topic guide

1. In general, do you think mental health and mental health difficulties are understood and spoke about a lot amongst people who have experienced homelessness?

Prompts: **a)** Do you think there is still a stigma attached to mental health difficulties amongst people who have experience of homelessness? **b)** Are there ever times when you may identify/observe that an individual may have mental health difficulties but they don't self-identify their experiences as mental health difficulties?

2. From your experience, can you identify the main areas of concern people who experience homelessness have with their mental health?

Prompts: **a)** What do people tend to come to talk to you about? **b)** What kind of difficulties do they discuss with you?

3. In your opinion, what aspects of the mental health services work well? And not so well? for people who have experience of homelessness?

Prompts: **a)** Are there barriers to accessing mental health support services? **b)** Are there adequate pathways to mental health support?

4. Are there particular issues regarding access to mental health services for people who may have a dual diagnosis of addiction difficulties and mental health difficulties?

5. Do you think the way we deliver mental health care needs to be tailored for people who have experience of homelessness? And if so, in what ways?

6. In some of the 1-1 interviews we have conducted so far with people who have experience of homelessness and mental health difficulties, some of them didn't think there was a relationship between their homelessness and their mental health; what do you think of this finding?

7. Similarly, many of the participants to date recalled that they didn't think they needed to seek support for their mental health difficulties until they were encouraged and/or facilitated to do so by Dublin Simon services; what do you think of this finding?

8. Are there specific issues you think may need to be addressed in the one to one interviews with people who have experience of homelessness?

Prompts: perhaps information which could be useful for your service?



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